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INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES RELATED TO BENEFIS HEALTHCARE'S COPA FOR FISCAL YEAR 1998

To the Montana Department of Justice:
215 North Sanders – P.O. Box 201401
Helena, Montana 59620-1401

We have performed the procedures enumerated below, which were agreed to by the Montana Department of Justice, solely to assist you in evaluating Benefis Healthcare's assertions regarding their compliance with the Patient Revenue Cap and related performance criteria imposed by Section I of the Certificate of Public Advantage (COPA) for the period from January 1, 1998 to December 31, 1998. The Patient Revenue Cap outlined in the COPA is implemented through a reporting mechanism known as the Revenue Cap Model, referred to as the Model.

On March 22, 1999, the Department of Justice approved certain changes to the COPA which were made retroactive to Benefis' fiscal year ending December 31, 1997. These changes were to

- Modify the expense reduction targets to reflect labor costs based on 5.71 full-time equivalents per adjusted occupied bed (FTE/AOB), and
- Change the inflation factor used in the model from the Producer Price Index (PPI) to the Health Care Financing Administration (HCFA) Market Basket Index (MBI).

We have incorporated these changes into this report.

(Throughout this report are references to the "submitted" and "revised" versions of the Model. Benefis Healthcare did not submit to Myers and Stauffer a completed version of the Model for the 1998 fiscal year. Rather, an abridged version of the Model was received by Myers and Stauffer on April 30, 1999. This model is not directly comparable to the version of the Model developed by the Department of Justice, but does perform similar calculations. In this report, the "submitted Model" refers to this abridged version of the Model provided by Benefis. The "revised Model" refers to the version of the Model incorporating Myers and Stauffer's adjustments, based upon the application of the agreed upon procedures discussed herein.)

This agreed-upon procedures engagement was performed in accordance with standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the Montana Department of Justice. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for

which this report has been requested or for any other purpose.

The procedures and the associated findings are as follows:

1. <u>Procedures related to Benefis Healthcare's assertions regarding the Patient Revenue Cap:</u>

A. Review Calculation of Baseline Total Costs

Procedures: We determined whether any services offered by the facility had changed significantly from the 1995 baseline period to the current reporting period.

Findings: There were no significant changes to the overall services provided by the combined facility during the current year and the baseline period. There have been a number of additional service consolidations, however, there were no service eliminations. We did not find any need to restate the baseline total costs.

B. Review Calculation of Allowable Total Costs

Procedures: We reviewed the expense reduction target and traced entries in the target worksheet to the various supporting documents in order to determine the total allowable cost. We recalculated total allowable costs in consideration of the modification to the COPA approved by the Department of Justice on March 22, 1999.

Findings: The applicable expense reduction targets were as follows:

	1997	1998
Per Original COPA	$3,394,069	$7,317,589
As Modified	$1,593,091	$4,915,240

We have incorporated the changes approved by the Department into both the 1997 and 1998 models.

C. Review Adjustment of Allowable Total Costs for Inflation

Procedures: We reviewed the HCFA Market Basket Index (MBI), for 1994 through 1995 to determine the appropriate inflation adjustment to include in the baseline adjustments to the Model, as well as the index for the current period.

Findings: Quarterly indices of the MBI have been incorporated in the baseline and current year sections of the adjusted model. Because the Department's approval of the MBI inflation index was made retroactive to 1997, the prior year model has been restated using the MBI. Indices were obtained from the *Health Care Cost Review* published by MacGraw Hill. We noted some minor differences from the inflation indices used by Benefis in the submitted model.

	Allowable Total Costs in Current Dollars	
	1997	1998
Per Original COPA[1]	$116,489,510	$113,198,426
As Modified	$119,354,331	$119,444,899

D. Review the Ratio of Casemix Adjusted Discharges

Procedures: We checked DRG groupings and recalculated the case mix for the facility to determine whether the stated case mix was accurate. We reviewed discharge counts using detail reports provided to us by Benefis.

We reviewed the DRG system in effect for 1995 through the current year to identify any significant changes in the overall system, as well as differences in the weighting of various DRG categories.

We analyzed the overall decrease in outpatient versus inpatient charges for the period of 1995 to 1998 to determine whether any differential occurred that would affect the computation of the outpatient adjustment factor. We reviewed the methodology used in the Model to incorporate skilled nursing service volume into the computation of Case Mix Adjusted Discharges.

We reviewed gross revenues reported for operating and non-operating categories on Worksheet 4 that are used as the basis for the Outpatient Adjustment Factor.

Findings: DRG version changes are implemented by Medicare on October 1 of each year; however, the COPA requires that CMI for each year be determined using the version of Medicare DRGs in effect as of January 1. We found that Benefis' submitted CMI for 1998 had been computed using the version

1. Per Original COPA is calculated using original expense reductions targets and the PPI inflation index.

of Medicare DRGs in effect on the date of service for each stay, with the result that DRG assignments for October, November, and December of 1998 used the wrong grouper and weights (for the purposes of the COPA). We regrouped all discharge records and computed the CMI for 1998 using the correct DRG versions and incorporated the results into the revised Model.

We revised the DRG classification submitted by Benefis for 51 discharges to reflect the correct grouper Version 15 DRG. The majority of these changes were for discharges with dates of service after October 1, 1998 when the grouper Version 16 was in use by Medicare.

We found that there have been some minor revisions to the DRG system since 1995; however, these are not significant enough to warrant complete re-basing of the 1995 data set.

Skilled Nursing Case Mix Adjusted Discharge Equivalent

Our analysis of the Model indicates that the number of skilled nursing discharges, and the derivative value for Skilled Nursing "Case Mix Index," does not have any effect upon the computation of total Case Mix Adjusted Discharges in the Model, for either the Baseline (Worksheet 2) or the Current Year (Worksheet 4). Because skilled nursing discharges are used in both the numerator and denominator of the calculations, it is the case that the value for "DRG Case Mix Weight Associated with SNF" is equal to Gross SNF Revenue divided by Gross Inpatient Revenue times Inpatient Total DRG Weights. We note that, although this is not an invalid method for computing a SNF volume measurement, the inclusion of SNF discharges in the displayed formulas may create the inference that SNF discharges are material to the calculation when they are not.

Outpatient Adjustment

The model estimates the volume and intensity of outpatient services based on the relationship between revenue for inpatient services (whose volume and intensity can be measured directly by case mix adjusted discharges) and total operating revenue. For example, inpatient revenue per case-mix adjusted discharge in the baseline period was $7,208, so for every $7,208 of outpatient and other operating revenues, an additional case-mix adjusted discharge was counted. Benefis reduced its prices for most services in 1997, and raised prices for many services in 1998. Gross inpatient revenue per case-mix adjusted discharge in 1998 was $6,313[2]. Because the

2. Per Worksheet 4 of the 1998 model, total inpatient gross revenue was $112,490,514 (line 6 + line 7) and there were

outpatient adjustment methodology is sensitive to differential changes in the prices for inpatient versus outpatient services, the question becomes "does $6,313 in 1998 outpatient revenues represent the same volume of services as $7,208 did in 1995?"

As detailed in Section 2 of this report, Benefis' pricing changes between 1995 and 1998 varied between service areas. As compared to the prior year, prices increased in both the inpatient and outpatient service areas by about 4% and 3% respectively. The model, however, requires a comparison of the current year pricing levels to the baseline year. In general, we estimate that inpatient prices have declined by about 6% and outpatient prices by about 15% from 1995 levels.

The Model, as designed by the Department's economic consultants, incorporated a mechanism for measuring differential changes in inpatient versus outpatient services between the baseline period and the review year. This measurement was to be accomplished through the sampling of charges for the 30 highest volume services delivered to each class of patients. This information would be recorded on Worksheet 11 of the Model, and the average price increase or decrease for inpatient services as a whole and outpatient services as a whole would be calculated. The Model then provides that should any differential be noted, the "auditor shall adjust the Case Mix Adjusted Discharge calculation to accurately reflect relative volumes among such services" (Section I.3), although the formula for this adjustment is not specified.

Prior year experience using Worksheet 11 demonstrated that the use of a sample of only 30 procedures was not sufficient to produce a reasonable outpatient adjustment. Using a larger sample of several hundred high dollar volume service items for each patient class, we calculated the average pricing changes for each of the service categories shown in Section 2.A of this report, and then weighted these changes by total revenues for the service category to arrive at an accurate estimate of overall changes in inpatient and outpatient service pricing. These amounts are then used to compute an adjustment to outpatient revenue in the model (at line 48e of Worksheet 4).

In the course of the pricing analysis procedures, a significant increase in outpatient supply revenue was noted. This increase was associated with

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17,817.76 inpatient case mix adjusted discharges (line 11). The quotient of inpatient gross revenue divided by inpatient case mix adjusted discharges yields gross revenue of $6,313 per case mix adjusted discharge.

supply item volume increases rather than price increases. It could not be explained by changes in the volume of outpatient clinical services, which were relatively unchanged from the previous year.

Through further data analysis and discussions with Benefis personnel, we determined that when the hospital consolidated the materials services systems of the East and West campuses in late 1997, standardization to a single, consistent inventory and billing system had the side-effect of causing a net increase in supply charges to patients. In some cases, items that were previously charged at only one campus were now being charged at both campuses. In other cases, standardization resulted in items that had been previously billed discretely being combined into "packs" or "kits" (it is not clear whether these particular changes had a net impact on supply charges). Finally, consolidation also resulted in improved billing efficiency; i.e., a greater proportion of billable supplies were consistently captured on patient bills.

Again, the net impact of the various billing changes was that an increased dollar amount of supply charges was being billed to patients for the same amount of actual supplies used. While the changes Benefis made in the materials services area were across the board, it so happened that the revenue increasing impacts occurred largely in the outpatient sector.

The increase in outpatient supply revenue does not represent a real increase in outpatient volume - it is effectively a price increase - and must be adjusted accordingly to avoid an unwarranted increase in the adjusted case mix discharges for the current year.

We have, therefore, included adjustments to our price change analysis to incorporate the effect of the changes in supplies billing. Our analysis led us to conclude that outpatient supplies charges at the 1998 level represent a 7.6% increase from 1997 levels. We incorporated this into the comparison of current prices relative to the baseline year.

With these adjustments, total case mix adjusted discharges for the 1998 period are 27,464.13 (Worksheet 4, Line 49).

E. Review Calculation of the Variable Cost Approximation in Current Dollars

Procedures: We reviewed the facility's calculation to determine the change in total allowable costs attributable to changes in acuity and volume.

Findings: The calculation is completed appropriately in the revised Model and indicates approximately $8.5 million of the total allowable cost varies directly with the overall volume and patient acuity within the facility, prior to the application of the fixed cost correction.

F. Review Calculation of the Fixed Cost Correction in Current Dollars

Procedures: We recalculated the fixed cost correction following steps outlined in the COPA and the Accounting Policies and Procedures.

Findings: The calculation is completed appropriately in the revised Model and yields about $2.5 million in fixed cost correction (Worksheet 5, Line 8).

G. Review Adjustment of the Allowable Total Costs in Current Dollars for Changes in Volume and/or Case Mix to Arrive at the Total Cost Target

Procedures: We reviewed the calculation of allowable total costs in current dollars after incorporating the other changes into the Model as well as the impact of volume and case mix changes on the total cost target for 1998. Additionally, the total cost target for 1997 was revised.

Findings: With the variable cost approximation and the fixed cost correction factored in to the Model, the total cost target for the current period is $125.4 million. The revised total cost target for the 1997 period is $126.8 million (Worksheet 5, Line 9).

H. Review Calculation of the Total Revenue Cap in Current Dollars

Procedures: Using information generated in the previous steps and incorporated into the Model, we recalculated the total revenue cap for 1998. We also recalculated the total revenue cap for 1997.

Findings: After incorporating various changes arising out of case mix index and revisions to revenue figures, the total revenue cap for 1998 is $133.4

million. The revised total revenue cap for 1997 is $134.9 million (Worksheet 6, Line 7).

I. Review Calculation of Patient Revenue in Current Dollars

Procedures: We revised the patient revenue included in the Model to incorporate the amounts from the audited financial statements. As part of this step, we reviewed the independent auditor's treatment of bad debts, charity care, and revenue related to the excluded service areas to ensure that they were appropriately accounted for. We also reviewed the discount offered by Benefis to its employee health benefit plan.

Findings: During the 1998 fiscal year, Benefis significantly increased the amount of charity care it provided. Total charity care reported for 1998 was $4.8 million, a $2.8 million dollar increase from 1997. This increase resulted from a mid-year decision by Benefis to increase the income thresholds in its charity care policy and to advertise these changes to the public. Benefis' decision to increase charity care was obviously of benefit to the uninsured patients receiving charity write-offs. This population represents an important component of the overall community, and therefore this action is consistent with the COPA's goal of reducing health care costs to consumers in Great Falls and the surrounding areas. However, should Benefis become over-reliant on charity care write-offs as a mechanism to keep revenues under the COPA imposed revenue cap, this will thwart a stated purpose of the COPA: price reductions to be passed on to the community at large. We recommend that charity care be closely monitored in future years to ensure that abuses do not occur.

Despite the dramatic increase in charity care, we noted that bad debt expense reported by the facility did not change significantly from the prior year. In theory, many of the uninsured patient accounts receiving a charity write-off would have eventually become uncollectible. It stands to reason that an increase in charity care would eventually produce a decrease in bad debt expense.

We reviewed the calculation of bad debt expense and the allowance for doubtful accounts as prepared by Benefis' independent financial auditor. It is our conclusion that bad debt expense reported agrees with the independent annual audit financial statements. The lack of a decrease in bad debt expense appears to be due to the combination of a change in the

method of estimation of the allowance for doubtful accounts introduced by Benefis' new independent auditors, and prior year estimations of bad debt that were understated. Again, we believe that bad debt expense and its relationship to charity care should be closely monitored in subsequent reviews of COPA compliance.

During the review of the 1997 fiscal year, Benefis requested that prior-year Medicare/Medicaid settlements accrued during 1997 be amortized over two years in accordance with Accounting Policy number 10 of the Model. This adjustment was made to the 1997 model, and a corresponding adjustment is appropriately made to the 1998 model to recognize this deferred revenue.

When properly stated in accordance with the Benefis' financial statements, and with a total of $636,069 in prior period Medicare/Medicaid settlement adjustments added to 1998 revenues, Adjusted Hospital Revenue subject to the revenue cap is $132.6 million (Worksheet 7, Line 18).

We found that the discount from full charges that was provided by the hospital to its self-administered employee health benefit plan was consistent with the discounts the hospital negotiated with other large health plans with "steerage" provisions.

J. Review Comparison of the Actual Patient Revenues in Current Dollars to the Patient Revenue Cap in Current Dollars

Procedures: We compared the calculated patient revenue cap to the established using the total cost target to the actual net patient revenue for the period. We also compared 1997 net patient revenue to the revised 1997 patient revenue cap.

Findings: Calculations in the 1998 model indicate that Actual Patient Revenues are under the Patient Revenue Cap by approximately $0.8 million. Per the revised 1997 model calculations, Actual Patient Revenue is in excess of the 1997 Patient Revenue Cap by $0.2 million (Worksheet 7, Line 19).

K. Review Benefis' Performance Relative to the 6 Percent Limitation Prescribed in the Certificate of Public Advantage.

Procedures: We reviewed the overall performance relative to the limitations imposed by the COPA as well as the overall charge structure in use at the facility.

Findings: The facility has not generated revenues in excess of the cap imposed by the COPA. A cumulative total deficit balance for the 1996-1998 period stands at $0.6 million (Worksheet 8, Line 8). This calculation incorporates a finding of $0.2 million in prior period surplus revenue, resulting from revisions to the 1997 Model to incorporate the retroactive modifications to the COPA approved by the Department.

2. <u>Procedures related to Benefis Healthcare's assertions regarding various performance criteria imposed by the Certificate of Public Advantage:</u>

A. Review claimed pricing changes.

Procedures: We reviewed the facility's charge master for the period 1995 to 1998 as well as the changes in relative pricing. We calculated per unit prices for both inpatient and outpatient services to determine if the pricing structure reflected what was reported in the charge master.

Findings: We have previously found that Benefis implemented a package of strategic pricing reductions in 1997 that included reduced room rates and ancillary service charges, with a particular emphasis on discounting prices for selected outpatient diagnostic and therapeutic services. Price changes during 1998 reflected primarily an upward trend with the most pronounced increases being for inpatient services. Price levels in 1998 were, however, lower than baseline levels overall.

Our review of service specific charges for the highest volume services in both the inpatient and outpatient settings indicated the following price changes between 1997 and 1998:

<u>Inpatient Services</u>	
Inpatient Routine Services	+3.7%
Inpatient Ancillary Services	+4.1%
Inpatient Services Total	+4.0%
<u>Outpatient Services</u>	
Operating Room, Recovery, and ASC	+6.8%
Radiology	+1.7%
Laboratory	-2.7%
Physical, Occup., and Speech Therapy	+1.3%
Cardiovascular	+2.6%
Medical Supplies	+7.6%
Pharmacy	-3.4%

Emergency	+2.9%
Ambulance	+3.5%
Home Health	+0.1%
Outpatient Services Total	+2.8%

The price change noted above for outpatient medical supplies includes our analysis of the effect of increases in outpatient supplies charges.

These price changes, in the aggregate, are comparable to pricing changes within the hospital industry that have taken place at the national level.

Although prices increased from 1997 to 1998, prices in 1998 were, in general, at levels below the 1995 pre-merger price levels. For example, outpatient operating room and related procedures *increased* 6.8% from 1997 levels, but this still represents a 30% *decrease* from 1995 pricing levels.

B. Review steps taken to reduce costs and improve efficiency.

Procedures: We reviewed the various steps taken by the facility to improve the overall operation and efficiency of the facility.

Findings: Total expenses for fiscal year 1998 increased by approximately $2.3 million or 1.7%, from 1997 levels. This amount is less than inflation as measured by the MBI (3.1%) for the corresponding time period. During this time patient volume decreased by 1.0% from 27,924 case mix adjusted discharges in 1997 to 27,646 case mix adjusted discharges in 1998. Expenses for 1998 were lower than 1996 levels by approximately $3.0 million.

C. Review any changes in full-time equivalent employees and resulting cost impact.

Procedures: We reviewed the facility's total FTE count at the beginning of the merger process as compared to the staffing levels at the close of fiscal year 1998.

Findings: The facility experienced a slight increase in staffing during the 1998 fiscal year. The total FTE count for 1998 is 1,700 compared to 1,687 in 1997. Staffing levels are however, below the June 1996 level of 1,891 FTEs.

D. Review any changes in services and functions of combined facility and resulting cost impact.

Procedures: We reviewed the facility's overall plan for streamlining operations at the combined facility as well as service consolidation plans.

Findings: The facility accomplished many of the consolidation plans during 1998. For example, psychiatric, rehabilitation, and certain outpatient services have become the focus of the West Campus. The East Campus is dominated by acute care services and has become the sole provider of maternity services. Building renovation projects that are scheduled to continue into the year 2000 will provide the infrastructure for remaining consolidation plans.

E. Review any changes in the volume or availability of inpatient or outpatient services offered at the facility.

Procedures: We reviewed the types of services offered in the pre and post-merger facilities as well as toured the facilities and discussed service availability and changes with hospital administration.

Findings: The service availability at each of the facilities considered independently has changed significantly with the consolidation, however, the overall distribution of service areas has not significantly changed. Overall service volume availability has not changed significantly with the consolidation; however, the facility continues to experience a decrease in inpatient days which is similar to decreases experienced at other facilities nation-wide.

F. Review the provision of charity and low-income care and community services provided by the facility.

Procedures: We reviewed the facility's policies for providing charity and indigent care as well as the overall dollar volume and program areas. In addition, we reviewed the minutes and activities of the community health council for the period.

Findings: We reviewed the facility's charity care policies for both the current year and the baseline year. As was previously noted, Benefis has significantly increased the size of its charity care program by decreasing its income guidelines for an uninsured patient to receive charity assistance.

The Community Health Council has made improvements in meeting its goals as set forth by the COPA. The Council is actively reviewing and commenting on the strategic plan of Benefis and has issued recommendations to the hospital at times. The Council has held a

community health forum and is planning a project to analyze the health needs of the Great Falls region. Although many of the Council's activities were still in the planning stage during 1998, there is an increased focus in its strategies. A portion of the increased effectiveness of the Council can be attributed to more active support from Benefis.

The Council also reviews consumer complaints related to Benefis' health care services, with a focus on matters that could be related to the COPA. Council activity relating to the review and resolution of patient complaints has increased from 1997 apparently due to increased community awareness of this function of the Council. The Council has in place procedures for the review of these complaints and appears to be achieving successful resolutions in most cases.

3. <u>Supplemental Procedures for this reporting period:</u>

The procedures enumerated above encompass all the procedures that were agreed to by the Department of Justice for the 1998 reporting period.

We were not engaged to, and did not perform an examination, the objective of which would be to express an opinion on Benefis Healthcare's compliance with the Patient Revenue Cap imposed by Section I of the Certificate of Public Advantage. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the use of the Montana Department of Justice and should not be used by those who have not agreed to the procedures and taken responsibility for the sufficiency of the procedures for their purposes. However, this report is a matter of public record and its distribution is not limited.

Myers and Stauffer LC
May 21, 1999

(Rec'd by Att'y Gen.
Nov. 10, 1999)